Medical Marijuana Program
DENIAL APPEALS APPLICATION
(Please Print)

Instructions: Use this form to appeal your county's denial of your application for a Medical Marijuana Program Identification Card. This form must be completed by you (the applicant) or by the legal representative specified below in Section 3. Within 30 calendar days from the date you were notified of your application denial, mail this completed form and a copy of your denied application to:

California Department of Health Services
Office of County Health Services
Appeals Desk, Medical Marijuana Program
MS 5203
P.O. Box 997413
Sacramento, CA 95899-7413

For further information, please contact the Medical Marijuana Program at (916) 552-8600.

Note: In order to process this appeal, the California Department of Health Services (CDHS) requires all applicable sections on this form be complete, including the signed declaration. Failure to furnish the authorization in Section 5 and all information required on this form will result in a denial of the appeal.

SECTION 1: INDICATE BY CHECKMARK BELOW IF THIS APPEAL IS FOR YOURSELF (APPLICANT), YOUR PRIMARY CAREGIVER, OR BOTH

☐ Patient (applicant) card ☐ Primary caregiver card

SECTION 2 COMPLETE THE APPLICANT INFORMATION BELOW.

Name (last, first, middle initial)

Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

SECTION 3 COMPLETE IF THIS SECTION IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Name (last, first, middle initial)			Telephone number ( )
Mailing address (number, street)	City	State	ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

SECTION 4 COMPLETE THIS SECTION IF THE APPEAL IS FOR YOUR PRIMARY CAREGIVER.

Name (last, first, middle initial)

SECTION 5 EXPLAIN IN THIS SECTION WHY YOU DISAGREE WITH YOUR COUNTY'S DENIAL.

Note: You may attach additional pages or type your statement on separate sheets and attach them to this form. Sign and date any additional pages.

Declaration *(Required)*

By submitting this appeal to the California Department of Health Services, I hereby authorize my county to release to the California Department of Health Services all information relating to my application for a Medical Marijuana Program Identification Card. I authorize this release for the sole purpose of reviewing and evaluating my appeal. This authorization is effective for the duration of the appeals process. I declare under penalty of perjury that the information on this form and any additional information submitted with this form are true and correct.

Print name of applicant or legal representative as identified in Section 3

Signature of applicant or legal representative as identified in Section 3

Date